CLAIM FORM
IN CLASS ACTION LAWSUIT
THOMPSON V. ROOB

I believe that I am a class member in the above identified lawsuit and I am requesting that the State determine whether or not I am a class member. If I am a class member, I also request an appeal of the State's denial of my application for Medicaid disability benefits.

My name: _____

My address: _____

_____

My telephone number: _____

My Social Security Number: _____

Date of Birth: _____

County where I applied for Medicaid Disability benefits when my application was Denied (if known): _____

Date of application (if known): _____

If you have a copy of the denial notice, please provide a copy.

My Signature: _____

Date: _____

Complete, sign and date this form and mail it to the following address **NO LATER THAN SEPTEMBER 18, 2007:**

Office of Medicaid Policy and Planning, MS-07
Attention: *Thompson v. Roob* Claims
402 W. Washington Street, Room W382
Indianapolis, IN 46204